P.O. Box 92 Kirkersville, Ohio 43033 Phone: 614-395-1395
email: info@pbjconnections.org

Participant's Application and Health History

GENERAL INFORMATION

Participant: ____
DOB: _______________ Age: ______ Height: _______ Weight: _______ M F
Address: ____
Phone: (H)________________________(W)_______________________(C)____________________________
Email:____
Employer/School: ____
Address: ____
Phone: ____
Parent/Legal Guardian: ____
Address (if different from above): ____
Phone: (H)________________________(W)_______________________(C)____________________________
Email:____
Referral Source (if applicable):____
Contact Numbers for Referral Source:____
How did you hear about the program? ____

HEALTH HISTORY

Please indicate current or past problems in the following areas:

	Y	N	Comments
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Digestion			
Elimination			
Circulation			
Emotional			
Behavioral			
Pain			
Bone/Joint			
Muscular			
Thinking/Cognition			
Allergies			

What medications are you (is your child) currently taking, including over-the-counter medications?

Describe your (your child's) abilities/difficulties in the following areas (include assistance required or equipment needed):

FUNCTION (i.e. Mobility skills such as transfers, walking, wheelchair use, driving/bus riding)

SOCIAL (i.e. Work/school including grade completed, leisure interests, relationships-family structure, support systems, companion animals, fears/concerns, etc.)

GOALS (i.e. Why are you applying for participation? What would you like to accomplish?)

PHOTO RELEASE

I

- ❑ DO
- ❑ DO NOT

Consent to and authorize the use and reproduction by PBJ Connections, Inc. of any and all photographs and any other audio/visual materials taken of me (my child) for promotional material, educational activities, exhibitions or for any other use for the benefit of the program.

Signature: ___________________________ Date: ______________
Client

Signature: ___________________________ Date: ______________
Legal Guardian

PAYMENT AGREEMENT

I, ______________________ (name of adult client or guardian of minor client) agree to pay PBJ Connections, Inc. at the current rate for services provided to me (or the client named above for whom I have legal responsibility). I understand that I am responsible for these charges and that fees are due at the time service is provided, unless I make arrangements in advance. If grant-funded, these policies only apply to late cancellation/missed appointment fees.

Client or Guardian Signature Date

Witness Signature Date